

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9034

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b X Port Tobacco	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last BROWN		4. DATE OF DEATH Month August Day 16 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Aug. 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY On Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Brown		14. MOTHER'S MAIDEN NAME Lusenda ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mary Queene - Daughter		Address Port Tobacco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation and Dehydration 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Senility (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Due to senility, refused to eat or drink	
20c. TIME OF INJURY Month, Day, Year No injury 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Port Tobacco, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11-59 , 19 59 , to 8-16-59 , 19 59 , that I last saw the deceased alive on 8-16-59 , 19 59 , and that death occurred at 11:15 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE V. B. DETTOR		ADDRESS (Street, city or town, state) La Plata	
PHYSICIAN'S NAME (Type) V. B. DETTOR, M.D.		DATE SIGNED 8-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/1959	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart		24a. REC'D BY REGISTRAR DATAUG 24 '59	
ADDRESS Archart Funeral Home, Inc. - La Plata, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. King	

CERTIFICATE OF DEATH

9034

Reg. Div. 114

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>10/15/1918</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Engineer</i>		7. MARITAL STATUS <i>Married</i>		8. PLACE OF BIRTH <i>England</i>		9. DATE OF BIRTH <i>10/15/1873</i>		10. PLACE OF BIRTH <i>England</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. DISEASE OR INJURY <i>Myocardial Infarction</i>		13. PERIOD OF ILLNESS <i>2 weeks</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>J. H. Smith</i>		17. SIGNATURE OF WITNESS <i>J. H. Smith</i>		18. SIGNATURE OF WITNESS <i>J. H. Smith</i>		19. SIGNATURE OF WITNESS <i>J. H. Smith</i>		20. SIGNATURE OF WITNESS <i>J. H. Smith</i>	

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his illness or who has been present at the death.

2. The cause of death should be stated in full, and the immediate cause should be stated first, followed by the remote cause, and so on, until the chain of causation is complete.

3. The date of death should be stated in full, and the time of death should be stated if known.

4. The place of death should be stated in full.

5. The signature of the physician or other person who has attended the deceased during his illness or who has been present at the death should be written in full.

6. The signature of the registrar should be written in full.

7. The signature of the witness should be written in full.

8. The signature of the witness should be written in full.

9. The signature of the witness should be written in full.

10. The signature of the witness should be written in full.

FOR STATE
HEALTH DEPT.

9035

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise G. Bryant		4. DATE OF DEATH August 16 19 59	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Elzie Butler		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 983X DUE TO Compound fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma of weapon (c) 8-15-59		INTERVAL BETWEEN ONSET OF DEATH 8-15-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit on head & weapon	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-15-59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Waldorf Charles Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. Edele		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20 1959	
22c. NAME OF CEMETERY OR CREMATORY Zion Wesley		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hugh Funeral Home		24a. REC'D BY REGISTRAR AUG 24 59	
ADDRESS Waldorf, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>47 X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Svedens Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>701-Brandywine Street, SE. Washington D.C.</u>	
c. LENGTH OF STAY IN lb <u>4-Hours</u>		d. STREET ADDRESS <u>701-Brandywine St. SE. Apt-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS W. CROWLEY</u> <u>William Thomas Crowley</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-54</u>
9. AGE (In years last birthday) <u>4-Yrs</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Allen Crowley--(Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>MARY WINCE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother-Mary E. Crowley</u>		Address <u>701-Brandy Wine St SE. Washington-D.C. Apt-3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Submersion</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Accidental Falling in Deep Water</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Child was missing about an hour when he was found in the deep water</u> <u>Potomac Mts. Rescue Squad tried to revive him without success</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15-Minutes</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child slipped into deep water when no one was around</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12-25-PM</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beach</u>		20f. (City or town) <u>Svedens Point</u> , (County) <u>Charles Co.</u> , (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James E. Andrews MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>17-Potomac Ave. Indian Head Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>FT MYER VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co</u>		24a. REC'D BY REGISTRAR <u>517-11-SPSE</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

NO. 12110 MEMBER OF

0030

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0030

DATE OF DEATH

PLACE OF DEATH

MARRIAGE

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. (Wash. D.C.) b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 16x-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians' Memorial Hosp.				d. STREET ADDRESS 9320 Old Fort Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Debra Lynn Donaldson				4. DATE OF DEATH Month August Day 21 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1959	9. AGE (In years last birthday) 19 days	IF UNDER 1 YEAR Months 19 Days 19	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Charles Co., Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Luther Donaldson				14. MOTHER'S MAIDEN NAME Emma Jean Willett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT John L. Donaldson, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration DUE TO Avitaminosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 772.0 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Feeding problem since birth							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward J. Edelen, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-25-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Arlington, Va	
23. FUNERAL DIRECTOR'S SIGNATURE The Unity Funeral Home, Waldorf, Md				24a. REC'D BY REGISTRAR AUG 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2066183XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WELCOME</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>PORT TOBACCO (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ON HIGHWAY</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DUNMORE</u> Last <u>DUNMORE</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 22, 1921</u>
9. AGE (in years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ON FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>CHARLES CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES DUNMORE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DENT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES. 1947-?</u>		16. SOCIAL SECURITY NO. <u>YES.</u>	
17. INFORMANT <u>MARIE EASTON-SISTER-WASHINGTON, D. C.</u>		Address <u>1607-D ST. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>1 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger - 2 car accident, Route #6</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 P. M. 8-24-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Welcome, Charles, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V. B. Dettor</u>		DATE SIGNED <u>8-24-59</u>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/28/59</u>		22b. DATE THEREOF <u>8/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins 4804 Indiana Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9039
CERTIFICATE OF DEATH**

09010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHAS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON AVE				d. STREET ADDRESS 1 WASHINGTON AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leo Middle K Last FARRALL Sr.				4. DATE OF DEATH Month AUG Day 9 Year 1959			
5. SEX MALE	6. COLOR OR RACE US-W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 13, 1885	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Drugs		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas R. Farrall				14. MOTHER'S MAIDEN NAME Sarah B. Hancock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-8896		INFORMANT Address Leo K. Farrall Jr., La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction. ptosis. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES						INTERVAL BETWEEN ONSET AND DEATH 4 hrs 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 50 , to 9 Aug , 19 59 , that I last saw the deceased alive on 9 August , 19 59 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE: Arthur O. Woody M.D.		ADDRESS (Street, city or town, state) LA PLATA, MD		DATE SIGNED 9 Aug 59			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE AUG 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

RECEIVED
JAN 19 1900

0032

DEPARTMENT OF HEALTH

STATE OF NEW YORK

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9040

Charles County

CERTIFICATE OF DEATH

09011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u># 12 EAST POPLAR</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>INDIAN HEAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>INDIAN HEAD, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#12 EAST POPLAR</u>		d. STREET ADDRESS <u># 12 EAST POPLAR</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ELIZA</u> Middle <u>HAWKINS</u> Last		4. DATE OF DEATH <u>8-29</u> 19 <u>59</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-4-1895</u> 64 yrs.
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHARLES CO. MD</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for how long) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS AMELIA KELLEY</u> Address <u># 12 EAST POPLAR</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>CARDIAC DISEASE, ARTERIOSCLEROTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION, ARTERIOSCLEROTIC</u> (c) <u>ARTHRITIS, DEGENERATIVE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 19, 1959</u> , to <u>AUGUST 24, 1959</u> , that I last saw the deceased alive on <u>AUGUST 29, 1959</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>		<u>ACCOKEEK, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-2-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Met. Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>HOMEROCK MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BARILES + MATHIAS</u> ADDRESS <u>3619-14500 WASH DC</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kinas</u>	

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VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9041
CERTIFICATE OF DEATH

09012

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>		d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN THOMAS JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 29 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 5, 1865</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARINER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEA-FARING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor McThane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Alice Thompson, Hughesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIO SCLEROSIS</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC URINARY PYELO-CYSTITIS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 YEARS</u> <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 1949</u> , to <u>AUGUST 29, 1959</u> , that I last saw the deceased alive on <u>AUGUST 29, 1959</u> , and that death occurred at <u>9:49 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Griffin</u>		DATE SIGNED <u>8/30/59</u>	
PHYSICIAN'S NAME (Type) <u>John H. Griffin</u>		EST. ADDRESS (Street, city or town, state) <u>Box 15, Hughesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-1-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Fields</u>		22d. LOCATION (City, town, or county) (State) <u>Hughesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>DATE SEP 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

CERTIFICATE OF DEATH

PLACE IN BOXES		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. OCCUPATION	
5. PLACE OF BIRTH		6. PLACE OF DEATH	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL		16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF CEMETERY OFFICIAL	
19. SIGNATURE OF HEALTH OFFICIAL		20. SIGNATURE OF DISTRICT ATTORNEY	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK	
23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CONSTABLE	
25. SIGNATURE OF TOWN CLERK		26. SIGNATURE OF TOWN MANAGER	
27. SIGNATURE OF TOWN BOARD		28. SIGNATURE OF TOWN MEETING	
29. SIGNATURE OF TOWN OFFICIAL		30. SIGNATURE OF TOWN OFFICIAL	
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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

9042

CERTIFICATE OF DEATH

11310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Victoria				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Victoria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jeanne Middle Mae Last Jupiter				4. DATE OF DEATH Month August Day 14 Year 19 59			
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/59		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wm. Jupiter				14. MOTHER'S MAIDEN NAME Annie Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Aspiration suffocation Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) At time of birth. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from midwife delivery , that I last saw the deceased alive on 8/14/59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10-29-59 DATE SIGNED ACTUAL SIGNATURE E. J. Edelen M.D. PHYSICIAN'S NAME (Type) E. J. Edelen							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/59		22c. NAME OF CEMETERY OR CREMATORY Shiloh		22d. LOCATION (City, town, or county) (State) Shiloh, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Zether				24a. REC'D BY REGISTRAR DATE NOV 3 59		24b. REGISTRAR'S SIGNATURE Arthur B. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1331
CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

RECEIVED
BALTIMORE
MAY 10 1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WELCOME		c. LENGTH OF STAY IN 1b X PORT TOBACCO	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE HARRISON KEYS		4. DATE OF DEATH Month AUGUST Day 24 Year 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9 1934
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE KEYS		14. MOTHER'S MAIDEN NAME MARGARET BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. YES	
17. INFORMANT INEZ KEYS-WIFE - PORT TOBACCO, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 816X DUE TO (b) Compound Fracture left femur Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. and tilia			INTERVAL BETWEEN ONSET AND DEATH 1 min. 1 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver - 2 car accident, Route #6	
20c. TIME OF INJURY Month, Day, Year 5:00 P.M. 8-24 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) WELCOME, CHARLES, MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V. B. DETTOR		DATE SIGNED 8-24-59	
EXAMINER'S NAME (Type) V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/27/59	22b. DATE THEREOF 8/27/59	22c. NAME OF CEMETERY OR CREMATORY Mc Conkie	22d. LOCATION (City, town, or county) (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins 4804 E. W. Ave. W.		24a. REC'D BY REGISTRAR AUG 26 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kinner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9044

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G246 8-14-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

09014

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CHAPEL POINT c. LENGTH OF STAY IN 1b 3 YEARS. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - BEL ALTON - CHAPEL POINT d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle A Last LYON		4. DATE OF DEATH Month AUG Day 6 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE US-W	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES HARKLER		14. MOTHER'S MAIDEN NAME MARY Godsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT MRS. HIRAM LYON, Bel Alton, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary insufficiency, arteriosclerosis DUE TO (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 3 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 48 , to 6 Aug , 19 59 , that I last saw the deceased alive on 6 August , 19 59 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Woody		M.D. LAPLATA MARYLAND DATE SIGNED 6 Aug 59	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 8 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Southland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf, Md		ADDRESS	
24a. REC'D BY REGISTRAR AUG 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

10011

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
INSTITUTE OF MEDICINE

10011

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JAMES HATHORN MARY GOSLEY

Mrs Hiram Linn, Bethel, Me.

Home

Mr

215-44-9 200

James G. Hathorn, 121 Cedar Hill Court

Hathorn, James G. 121 Cedar Hill Court

9045

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09015

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELINOR MORRIS		4. DATE OF DEATH August 24 19 59	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20/1924
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 4 Hours 19 Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cleveland Morris		14. MOTHER'S MAIDEN NAME Pauline Dyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pauline Jacks		Address La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and hemorrhage 812X DUE TO (b) Basilar Skull Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 1 min. 1 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway (301) - Pedestrian struck by car	
20c. TIME OF INJURY Month, Day, Year 1:35 p.m. 8-24-59	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) La Plata, Charles, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V.B. Dettor		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V.B. DETTOR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Smith Funeral Home, Waldorf, Md.		ADDRESS 28 '59	
24a. REC'D BY REGISTRAR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

0042

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0010

1. Name of Deceased: John J. Smith

2. Age: 45 Sex: M

3. Date of Death: 10-15-1918

4. Place of Death: Home

5. Cause of Death: Heart Disease

6. Manner of Death: Natural

7. Signature of Medical Examiner: [Signature]

8. Date of Examination: 10-15-1918

9. Name of Coroner: [Signature]

10. Date of Coroner's Report: 10-15-1918

11. Name of Physician: [Signature]

12. Date of Physician's Report: 10-15-1918

13. Name of Undertaker: [Signature]

14. Date of Undertaker's Report: 10-15-1918

15. Name of Burial Place: [Signature]

16. Date of Burial: 10-15-1918

17. Name of Burial Place: [Signature]

18. Date of Burial: 10-15-1918

19. Name of Burial Place: [Signature]

20. Date of Burial: 10-15-1918

9046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Issue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARCELLUS</u> First <u>SCOTT</u> Middle Last		4. DATE OF DEATH Month <u>AUG</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 OCT 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Plowden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>115-07-4156</u> INFORMANT <u>Sally B. Scott, Issue, MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Respiratory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral vascular accident.</u> DUE TO <u>2 days.</u> (c) <u>Hyper-tensive Cardiovascular disease</u> DUE TO <u>5 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>12 August</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 August</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		ADDRESS (Street, city or town, state) <u>LaPlata.</u> DATE SIGNED <u>12 Aug 59</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		<u>Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Newburg MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 17 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Robert S. Thoms</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9047

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRANCES Catherine THOMAS</i>		4. DATE OF DEATH <i>Aug 1 19 57</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 24, 1914</i>
9. AGE (In years last birthday) <i>44</i> yrs.		10. IF UNDER 1 YEAR: Months <i>4</i> Days <i>4</i> Hours <i>4</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Woodland</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>James Thomas, La Plata, Md.</i>	
17. INFORMANT <i>James Thomas, La Plata, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Malignant hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 mos. 5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1955</i> to <i>Aug 1 1957</i> , that I lost s/he the deceased alive on <i>Aug 1 1957</i> , and that death occurred at <i>7:30 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson MD</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>8-1-57</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-4-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Newport, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Aug 5 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1920		BALTIMORE, MD		JAMES H. HARRIS		JAN 15 1940		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL PLACE	
JAN 15 1940		BALTIMORE, MD		JAMES H. HARRIS		BALTIMORE HOSPITAL		JAMES H. HARRIS		BALTIMORE CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF BURIAL PLACE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
JAMES H. HARRIS		BALTIMORE HOSPITAL		JAMES H. HARRIS		BALTIMORE CEMETERY		JAMES H. HARRIS		JAMES H. HARRIS	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF LOUISIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSISSIPPI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ALABAMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF GEORGIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF FLORIDA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF SOUTH CAROLINA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NORTH CAROLINA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF VIRGINIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WEST VIRGINIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MARYLAND. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF DELAWARE. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF LOUISIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSISSIPPI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ALABAMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF GEORGIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF FLORIDA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF SOUTH CAROLINA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NORTH CAROLINA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF VIRGINIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WEST VIRGINIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MARYLAND. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF DELAWARE.